AN UPDATE
AND
RECOMMENDED IMPLEMENTATION ARRANGEMENTS FOR AID CROSS BORDER HEALTH ASSISTANCE ACTIVITIES TO IMPROVE THE HEALTH OF WAR-AFFECTED AFGHANS

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I. EXECUTIVE SUMMARY

The people of Afghanistan have suffered terribly since the 1978 "Revolution" with over one-half million dead, four million refugees, and over one and one-half internal refugees--displaced from their homes. The US Government, through AID, has begun humanitarian efforts to help these courageous people, including a cross-border assistance program in health. In November and December of 1985, a health planning team began the planning efforts and wrote a document entitled Recommended AID Cross Border Humanitarian Assistance Activities to Improve the Health of War-Affected Afghans. This document, also serving as an interim health sector strategy, resulted in AID approval of an Activity Identification Memorandum (AIM) endorsing the elements of the proposed health sector activities but asking the USAID Office of Afghan Affairs to complete the planning process and submit another document for final approval. This report is that document and is submitted for approval as an Activity Approval Memorandum (AAM).

The proposed health activity's purposes have not changed nor has its strategy to achieve those purposes. Simply stated, these are to expand health services inside Afghanistan as rapidly as possible and strengthen the capability of the health committees of the Seven Party Alliance to plan, operate, and monitor expanded health services in Afghanistan. The strategy is to carry out a massive training effort to "fill up" the nearly empty health system with trained workers who can care for war injuries and the civilian population, and to make available the necessary drugs, medical equipment, and medical supplies to support an expanded health care system inside Afghanistan.

During the four months between the health planning team's visits, the war had intensified, especially in the border areas, and casualties were high among civilians and mujahiddin. In Pakistan, the change from Martial Law to a civilian government and the planning for the UN-sponsored Geneva VII proximity talks had dominated the attention of those GOP officials concerned with Afghan affairs. In the health sector, the AID-funded PVOs had started their training programs. They had established a coordinating body called the CMC (Coordination of Medical Committees) to share training experiences, to develop standard drug lists, and coordinate, to a limited degree, with the party health committees. The seven party health committees had made little, if any, progress due to lack of funds and lack of organizational capacity. AID staffing had improved considerably and the USAID Mission was able to function much more effectively.

Many issues have been clarified since the previous report. It is now clear that medical equipment through Department of Defense excess property should be viewed as supplementary to the expected needs, rather than forming a basis on which to plan. It is now likely that the McCollum Amendment which offers transportation support will likely be available on a multi-year basis and should be able to finance most of the transportation costs to Pakistan, within Pakistan, and inside Afghanistan.

At the beginning of the health planning team's second visit, the Afghans were somewhat dubious about AID's potential contribution. Six months had elapsed and AID was still in the planning stage! Even though the delays were explainable, the party health committees voiced disappointment, particularly since AID was funding PVOs but not them. Over the five week visit, considerable progress was made in organizational development of the Alliance Health Committee and in improving the coordinating mechanisms between the PVOs and the Alliance Health Committee. The Alliance developed several policy measures related to AID assistance in health, both for itself and for PVO coordination. They developed an initial plan for a cross-border health program management unit, to be called the Alliance Secretariat, which included various departments to carry out the cross-border program. Serious discussions were held about how AID might disbuse funds and how a technical assistance team would relate to the Secretariat and the Alliance Health Committee. At the end of the visit, the Afghans again have high expectations of creating an Alliance-led health services system in Free Afghanistan.

The visit clarified the roles and coordination mechanisms of the various implementing institutions. The Alliance will, over time, be responsible for operating the health services inside Afghanistan through the management mechanism of the Alliance Secretariat, (subject to adequate AID funding). Most PVOs will coordinate with the Alliance in the nomination and selection of trainees and, to the extent required, in other areas until the Secretariat is functioning adequately. The technical assistance team will help both the Alliance and the PVOs. The Government of Pakistan's views are not yet clear. AID will monitor PVOs and the technical assistance team directly, and will expect the technical assistance team to help them monitor the activities of the Alliance. The health project will retain its own project medical supply service and plans to rely on the Commodity Export Program to assist with movement of goods from the US to Pakistan. The implementation schedule is similar to the MSH Reference Report and cannot be improved until the amount of funding is known.

Five options for the financial administration of AID funds were analyzed and one is clearly preferable. At the beginning of the development of the Alliance Secretariat, it is preferable for an intermediary organization with strcng financial planning and management skills to manage and disburse funds to the Alliance on AID's behalf. The intermediary organization will maintain tight financial control in the earliest stages and pass financial control to the Secretariat based on their ability to use and account for AID funds satisfactorily. This same organization will provide technical assistance in training, supply management, health operations, and organizational development of the Secretariat.

The proposed program was developed with the Alliance and is endorsed by the Alliance Health Committee. The Afghans are eager to proceed and need help fast--the war continues every day and the pressure on the Afghan people is constant, brutal, and creates great suffering. It is important that AID not lose credibility by delays in approval or by approving marginal amounts of funds.

II. INTRODUCTION

A. OBJECTIVES OF THIS REPORT

The overall objective of this report and its Annex is to be an Activity Approval Memorandum (AAM) for the Afghanistan Health Activity (306-0203). This report is based on the MSH document entitled Recommended AID Cross Border Humanitarian Assistance Activities to Improve the Health of War-Affected Afghans, dated January 10, 1986, and incorporates this report by reference. In late January, 1986, the AID Assistant Administrator for the Asia and Near East Bureau, through the mechanism of the Asia and Near East Project Advisory Committee (ANPAC), reviewed the MSH report and agreed to approve it as an Activity Identification Memorandum (AIM). The ANPAC requested the AID Representative for Afghanistan Affairs to develop an AAM for AID/W approval based on the MSH report "with emphasis on rapid impact elements" and taking into account the guidance described below.

Guidance from the ANPAC

Budget: It is unlikely that all the funds requested for health activity will be available. Several relevant factors have not yet determined such as extent to which DOD may be able to provide commodities or cover transportation costs and the extent to which Section 451 funds may be used for PVO grants. As such, the AID Rep should determine allocations for the total Afghan program and advise AID/W of the FY 86 obligation amounts. A minimum budget for high priority items should be determined for all sectors. This would provide flexibility for adding activities as funding levels allow. In health, the project elements are approved but AID/W requests that AAM indicate which elements at what funding level can be accommodated within anticipated budget availabilities and what information and evaluation criteria will be available to determine whether or not the project should be expanded at some point in the future.

Implementation Arrangements: The AAM should describe the administrative and institutional arrangements through which implementation will occur, including the roles of the health committees of the Seven Party Alliance, GOP/PWI roles, coordination with PVOs operating in the health sector, and how a technical assistance team would operate.

Salary Support: The ANPAC agrees that salary support and family support are appropriate and necessary elements to enable workers to return to or remain in Afghanistan and requests that every effort should be made to keep these long-term recurrent costs to minimum essential levels.

Technical Assistance Team: The ANPAC discussed security concerns associated with posting additional Americans in the area, but concludes that the project cannot be implemented without technical assistance.

The specific objectives of this report are to provide a brief review of the MSH Reference Report, an update of the recent developments in Afghanistan and Pakistan affecting the proposed health activity, and to address the relevant topics in the ANPAC guidance described above.

B. BRIEF REVIEW OF MSH REFERENCE REPORT

The people of Afghanistan have suffered terribly since the 1978 "Revolution" with over one-half million dead, four million refugees, and over one and one-half million internal refugees--displaced from their homes. Since 1979, a spontaneous resistance to the Karmal regime and the Soviet invasion has developed, with many trials and tribulations, into a fragile alliance of seven parties linked somewhat loosely to many military commanders inside the country. Of the approximately 12 million people living in Afghanistan, about 9 1/2 million live in "free" areas, but Soviet tactics are exacting a heavy price and emigration to Pakistan and to Kabul are increasing. Deaths attributed to the war have raised the death rates by 58-105%; illness problems are similar to before the war--only worse--and epidemics of measles and other diseases particularly take their toll on the displaced persons. In militarily active areas, civilian casualties are thought to be 3-4 times mujahiddin casualties.

Both parties and a number of PVOs are trying to provide services inside Afghanistan but the numbers are low relative to the need. The parties have limited funds and the refugees claim a great deal of their time and resources. Given the lack of funds and the lack of administrative experience, the party health committees are not very well organized, although there is

a great amount of variability. A number of organizations have been training "first aiders" and a few are beginning to train nurses for war-related health work. Drugs and medical supplies are available through some foreign organizations and are not in such short supply if their usage is matched with the number of trained workers inside the country. However, as the workers increase, many more drugs will be needed. Medical equipment is in short supply.

The health activities will follow a number of strategic principles to gain and maintain the confidence of the Afghan parties and to help minimize the "push" factors that the Soviets and Karmal government are using to drive the population into Pakistan or into government-controlled areas. These include respect for the values of the Jihad; concern about food and shelter, as well as health; the importance of meeting the health needs of civilians as well as fighters; and the need for flexibility, recognizing that the Soviets and Karmal government will try to develop countervailing strategies. The program itself has three objectives--to expand and improve (1) medical and surgical care for war casualties; (2) general health care for civilians as well as mujahiddin; and (3) the capability of the Health Committees to plan and manage expanded health activities to better support the war effort and eventual national reconstruction. To accomplish these objectives, emergency care services in Afghanistan will be expanded by training more first aiders and nurses; urgent care will be improved by setting up Mobile Health Clinics, small Mobile Surgical Hospitals, and larger, semi-permanent Combat Surgical Hospitals in more secure areas; evacuation systems will be improved; and some funds may be made available for expanded beds for women and children in Pakistan. The training strategy is to build on strengths of the PVOs and parties but also to increase the capability of both, so that training can be rapidly expanded. AID will finance the costs of a supply service to provide equipment, drugs, and expendable medical supplies. AID will also finance transportation costs as required. Portions of AID assistance, including some transportation costs, will be supplemented from funds available through the McCollum amendment.

C. THE ROLE OF THE REFERENCE REPORT AS A HEALTH SECTOR STRATEGY

Conventional AID practices dictate that policy guidance is decided in Washington but that the field missions develop the strategies to implement the policies. The overall strategic plan is written as a Country Development Strategy Statement (CDSS) with a strategy for each sector in which the mission plans to have a program. Due to the circumstances in which the Office of Afghan Affairs operates, a broad overview report by Mr. Larry Crandall functioned as a CDSS and then the actual programming cycle began. As such, a detailed health sector analysis and strategy did not exist when the MSH Reference Report was written.

The MSH Reference Report was written to function both as an interim health sector strategy and as a programming document. As such, it is meant to provide guidance for <u>all health sector activities</u> of the USAID Office of Afghan Affairs. Its goal, purposes, outputs, and implementation strategies are meant to include potential activities of both the Alliance and the Private Voluntary Organizations. Section III of this report will update that reference report with particular guidance on the desired role of PVOs in the overall health sector program.

D. RELEVANT DEVELOPMENTS IN AFGHANISTAN AND PAKISTAN DURING JANUARY-APRIL 1986

Since the health team's departure from Pakistan in late December, 1985 to its return about May 1, 1986, a number of relevant developments had occurred in Afghanistan and Pakistan. In Afghanistan, the war had intensified since early Spring and the Soviets and DRA strategy had been to reduce mujahiddin access inside Afghanistan by sealing off the border areas. There were several important battles, heavy bombing, efforts to set border tribes against each other, and reports of crop and village destruction. As might be expected, there were heavy casualties among both mujahiddin and civilians and, in many areas, food supplies for this upcoming winter are expected to be in short supply. Unfortunately, the Soviets and DRA were relatively successful--the movement of mujahiddin, supplies, and equipment has been diminished and the costs of transport has increased. On the Pakistan political front, the change from a Martial Law to a civilian government and planning for the UN-sponsored Geneva VII proximity talks had dominated the attention of those GOP officials concerned with Afghan affairs

and slowed down GOP approvals for the final humanitarian assistance design activities. The GOP had also apparently changed its policy toward the use of Pakistan Welfare International (PWI) as a lead organization for humanitarian assistance to Afghans.

In the health sector, most PVOs began to train their first classes and were preparing to place their graduates inside Afghanistan. As such, they were extremely busy. Some PVOs tended to operate rather independently while other PVOs had established training linkages and were training each others students in selected subjects. In general, PVO collaboration had been on the increase and the PVOs had formed a body called the Coordination of Medical Committees (CMC) for coordination purposes. The overall goals, policies, and procedures of the CMC were still under discussion but actions had included sharing of training experiences, development of a standard list of drugs and treatment protocols, and coordination, to a limited extent, with the party health committees. The CMC-party health committee meetings had variable attendence by party representatives and, at times, by PVO representatives. These meetings did raise a number of issues where there was a wide difference of opinion among the two groups.

At the time of the team's arrival on May 1, most of the PVOs had only limited linkages with the health committees of the political parties in selection of trainees, usually preferring to establish their linkages for student selection and deployment directly with military commanders responsible for various field areas inside Afghanistan. They had gained more experience at training and most planned to operate their own health services inside Afghanistan. Some PVOs were cooperating with each other in planning their health services inside Afghanistan while others were working by themselves with selected commanders. The PVOs had minimal, if any, service planning linkages with the party health committees.

In December, 1985, while the health team was in Peshawar, the leader of the Seven Party Alliance announced the formation of a Seven Party Alliance Health Committee. The members of that committee had met with the health team prior to the team's departure. As of the arrival of the health team around May 1, 1986, the Alliance Health Committee (AHC) had not yet again met except when requested by the CMC. More disappointingly, the Ibn-e-Sanna Hospital, previously operated by three of the parties, had been under dispute and was only being operated by one of the parties--the other two being without facilities. The parties themselves had made little progress in health. As noted

in the previous MSH report, the capability and health activities of the individual parties inside Afghanistan vary widely. Only two or three of the seven parties have clinics and a few small hospitals in operation inside Afghanistan. During these last four months, two of the party health committees (Sayyaf and Hezb-i-Islami-Gulbaddin) had training programs underway. However, it is unlikely that any expansion in services has actually occurred. The parties were still hampered by shortages of funds, lack of trained health care providers, lack of managerial and logistics skills, and heavy responsibilities for Afghans living in Pakistan.

It is important to note the important changes in AID capability during this time period. In December of 1985, the AID Representative received his first permanent professional staff member. In March, the health sector was assigned to a newly arrived staff member. By May 1, there were four direct hire staff in Islamabad plus a representative in Peshawar. This enhanced capability is very important in the health sector as a number of areas required AID attention.

E. STATUS OF COMMODITY SUPPORT THROUGH DOD EXCESS PROPERTY AND TRANSPORTATION SUPPORT THROUGH THE McCOLLUM AMENDMENT

At the time the previous report was written, it was not clear whether DOD excess property or transportation funds through the McCollum Amendment would substantially reduce the costs to AID for medical equipment and for transportation. In February, following a series of discussions with the Office of Humanitarian Assistance at the Department of Defense, it became clear that DOD excess property would not repeat not likely be available in the quantities required nor in a timely fashion to meet the vastly expanded needs envisioned by the health activities. In fact, medical equipment from DOD excess property should be viewed as supplementary to the expected needs. As a result, AID should plan to purchase such equipment with AID funds and so indicate in the budget.

While the situation vis-a-vis DOD excess property was financially disappointing, the situation vis-a-vis the McCollum Amendment is quite positive. At the present time, it appears likely that McCollum funds will be made available on a multi-year basis and significant portions of those funds will be made available to the AID Office of Afghan Affairs for use in financing transportation costs in Pakistan and inside Afghanistan. As such, the AID-financed budget for transportation costs for the health sector will be substantially reduced.

F. RESULTS OF THE HEALTH TEAM'S VISIT

This subsection summarizes the activities and results of the health planning team's five week visit to Pakistan. Details of the meetings are found in the Annex.

Within the first two days of arrival in Peshawar, the health team attended two meetings--one with the CMC and one where the CMC and party health committee members met together. It was clear that there were strong differences of opinion between the groups regarding responsibility for planning, organizing, training personnel, and delivering health services inside Free Afghanistan. The PVOs were proceeding with their plans of action essentially as before the establishment of the AHC in December--with varying coordination among themselves and minimal coordination with the parties or the Alliance Health Committee. Since the AHC hadn't been meeting before the health team arrived (except when called by the CMC), the PVOs felt that their position was both practical and reasonable and, in addition, suited their preferences on the whole. They clearly wanted to operate independently of the parties in training as well as in planning and implementing health services inside Afghanistan. They perceived their best coordination link to be with commanders--only if necessary did they want coordination with parties or an AHC. Their position at the beginning of the health planning team's visit might be summarized as follows.

General Views of the PVOs

-The party health committees are not organized.

-When the PVOs have attempted to clear potential students through the parties, the parties have failed to follow-up and do their part.

-The Alliance is politically motivated and unable to agree on organizational issues.

-The Alliance cannot be trusted to deliver goods and services inside Afghanistan, rather they are mainly concerned with Peshawar-based health services.

-External resources would mostly be diverted into Pakistan for refugee programs or private practice.

-Selection of trainees will be on political and family grounds rather than on merit or willingness to work inside Afghanistan.

-The party members don't come to coordination meetings on a regular basis.

The Alliance Health Committee expressed a different position centering around the issue of "control." Their initial position may be summarized as follows:

General Views of the Alliance Health Committee

-The AHC should have responsibility for coordinating and approving all cross-border health activities.

-The AHC should control PVO health activities and all AID funds in health.

-The AHC felt that the PVOs were "out of control" and this was harmful to the resistance movement; that they posed security problems; and that it is inappropriate for foreigners to operate their own programs inside Afghanistan.

-The AHC was disappointed to find out that some PVOs were receiving AID funds while the Alliance was not yet receiving any AID funds. They wondered about AID's motives.

-The AHC felt that if they had funds for staffing and for training, they could do the job that the PVOs had begun--better and at lower cost!

The health planning team began a process of meeting alternatively with the AHC and the CMC. The AHC was refreshed on the previous MSH report, briefed on the AID/W meetings, learned more clearly why there had been delays in the follow-up visit, and were reassured that AID was still interested in an Alliance Health Program and was prepared to act promptly to get final approval. The AHC was asked to give its views on how best to proceed with cross-border health sector activities and they produced "Eight Principles" on which further discussion should be based. The MSH team, with the concurrence of the AHC, then presented the "Eight Principles" to the PVOs in a CMC meeting, briefed them on other pertinent impressions and presented the health planning team's views on the administrative arrangements. The CMC members commented on the "Eight Principles" and on the administrative and institutional arrangements under discussion. The revised "Eight Principles for AID Assistance in Health" are as follows:

Eight Principles of the AHC for AID Assistance in Health

1. The priority need is for the training of first aides and mid-level personnel.

2. The training programs for first aides and mid-level personnel should have a standardized curriculum, training materials, and manual.

3. The recruitment of persons for training will occur in accordance with the principles and policy of the Alliance Health Committee.

4. AID assistance in health should be exclusively given to the AHC for both training of personnel and provision of health services inside Afghanistan. The AHC should be the main implementing organization for cross-border programs. PVOs which implement health services inside Afghanistan must have the agreement of the AHC before carrying out such services.

5. Cash assistance should be paid to technical personnel (first aides, technicians, nurses, and doctors) when they are under training and conducting their duties in the homeland.

6. Employment of technical personnel inside Afghanistan should take place within the framework of the AHC and only after the approval of the AHC.

7. The appointment of technical personnel in Afghanistan (numbers and locations) will be by the AHC, following consultation with the military committee of the resistance parties within the Alliance, and is dependent on the needs of the mujahiddin and civilian population.

8. The AHC finds it necessary to establish housing and classroom space for students undergoing training in health courses.

Following this, another two meetings occurred with the AHC focusing on project administration (formation of an AHC Management Unit called the AHC Secretariat, staffing of the Secretariat, coordinating linkages with the CMC, how AID funds would be administered and disbursed, etc), and then a final wrap-up meeting with the CMC was held.

The results of these meetings plus a number of informal discussions with PVO members and some party health committee members, were as follows:

Final Views

PVOs

-Most PVOs are be willing to coordinate their efforts with the Alliance Health Committee when it is organized and has a program, although with some reservations and many anxieties.

-Most PVOs are willing, in principle, to work within the context of the "Eight Principles" with the exception of Principle 4 which requires further discussion. They feel strongly that many of the other principles need further clarification plus detailed implementation procedures and their agreement is subject to acceptable clarifications and procedures.

-PVOs view training as a major part of their activities but also are interested in operating health services inside Afghanistan themselves.

Alliance Health Committee

-The AHC endorsed the cross-border program and wants to be the responsible group to manage it.

-The AHC is willing to have support from PVOs who are willing to follow the "Eight Principles" enunciated by the AHC.

-The AHC accepted, in principle, the administrative and financial arrangements discussed in Section IV of this report.

In addition to the discussions with the CMC and the AHC as described above, the health planning team made a number of field visits and spent considerable time on adjusting the outputs and budgets to three possible funding scenarios: a minimum program, a moderate program, and a maximum program. The team also worked with USAID's program office on health sector ABS planning.

The most important impressions by the health planning team were the very positive attitudes of the AHC toward a coordinated Alliance-oriented, rather than party-oriented, approach. They also showed considerable maturity in their decision-making regarding the Alliance itself and about the Alliance-PVO relationship. The PVOs, while willing to coordinate, will not press the issue and expect the AHC to take a year or so to get organized and operational--even with technical assistance. The health planning team felt that considerable progress had been made on these coordination problems and that, once an Alliance Health Program started and both the AHC and the PVOs were busy, these problems would be solvable through the combined efforts of the technical assistance team and the USAID mission.

III. SELECTED UPDATE OF MSH REFERENCE REPORT ON THE ROLE OF PVO'S AND ON PROJECT OUTPUTS

Based on (1) the ANPAC guidance to focus on rapid impact elements in health and to accomodate the level of outputs to anticipated budget availabilities; (2) the relevant developments in Afghanistan and Pakistan during January-April 1986; (3) the clarification of commodity support through DOD and transportation support through the McCollum Amendment; and (4) the outcomes of the team's visit, it is worthwhile to update the MSH Reference Report on the role of PVO's and on the project outputs. However, while this update is important, it is crucial to note that the goal, the three objectives and the overall strategy are unchanged.

A. GUIDELINES FOR THE ROLE OF PVO'S IN THE OVERALL HEALTH PROGRAM

The first MSH Report described the purposes and outputs for all proposed health sector activities, but did not adequately address how PVO health activities should be carried out within the context of the overall AID cross-border humanitarian program in health. At that time, it was not clear if Pakistan Welfare International might be constituted or whether Section 451 grants would be separately administered by Washington. At the present time, it appears that PWI may not play an administrative role and that all USG funds available for cross-border programs will be in the AID ESF account under the overall guidance of the Asia Near East Bureau of AID and managed by the Office of Afghan Affairs.

AID is currently funding a number of PVOs who receive funds from other sources as well. Several are non-American organizations. At the present time, several additional PVOs are requesting support and the currently funded PVOs are requesting more funds for the coming years. The sum of these requests exceeds the presently available funds for the entire AID program, not just the health sector! For AID to make decisions about PVO health program funding, guidelines on the desired role of PVO's in the overall health program are useful.

In the MSH Reference Report, there were three purposes--all approved by AID/W. The first two are concerned with rapid expansion and improvement of health services to the people in Afghanistan and the third is concerned with strengthening the capability of the Health Committees of the Seven Party Alliance to plan and manage AID-assisted health activities inside the country. This second report reconfirms the importance of all three purposes but suggests that the first two--rapid expansion and improvement of health

services to mujahiddin and civilians--take precedence over the third purpose in the short run. If this assumption is accepted, it is possible to establish some overall guidelines for the role of PVO's in the overall health program that may assist decision-making from the technical and organizational points of view. The guidelines may be stated as follows.

Guidelines for the Role of PVO's in the Overall Health Program

1. In the short run (1-3 years), PVO's are necessary to meet the purposes of rapid expansion and improvement of services inside Afghanistan. As such, continued funding of PVOs whose programs support these purposes is important. The most important task to rapidly expand and improve health services inside Afghanistan is training of first aides and nurse/paramedics. Those PVOs with the current or potential capacity to rapidly expand their training efforts to help "fill up" the country with trained workers should be encouraged to do so and receive priority for funding among PVO applicants.

2. Since the critical role for PVOs in the short run is training, PVOs should focus their efforts on a rapid expansion of training, rather than on operating their own health services and programs inside Afghanistan. If and when they operate health services and programs inside Afghanistan, they should view these activities as extensions of their training efforts and use them to improve both their own training and the training and health services carried out by the Alliance. The Alliance should have the responsibility for operating health services and programs inside Afghanistan.

3. PVOs should be evaluated on the quality of their training programs in imparting standardized core skills to trainees, on the volume of their output, and on their cost per graduate by the type of worker trained. The PVOs should receive their drugs and supplies through the overall health project channels.

4. PVOs should be encouraged to support the third purpose of strengthening the capability of the Alliance by coordinating with the Alliance in the planning and operation of training programs and in resolving issues which are detrimental to the empowerment of the Alliance Health Committee and Alliance Health Program. At the same time, PVOs should not repeat not become involved in other

activities which might slow down their training efforts. The main purpose of PVO programs is rapid expansion of trained personnel and AID should support the PVOs and protect them as well so that this purpose is achieved.

5. The role of PVOs may change over time as the Alliance becomes stronger and more capable in the training areas. While AID should encourage the PVOs to concentrate on their training programs in the short run, AID should consider additional roles for PVOs in the medium term.

B. PROJECT OUTPUTS BY LEVEL OF FUNDING

The following three pages contain tables with outputs by year for a minimum health sector program, a moderate program, and a maximum program--based on different funding levels. Financial tables supporting these outputs and all other project costs are found in the Annex.

It should be noted that the rapid impact elements are given priority and longer range impact elements such as medical and nursing education and additional beds for women and children are deferred until project year four and five.

The cost tables in the annex attribute 75% of the project transportation costs to McCollum funding and 25% to AID funding.

TABLE OF PROJECT OUTPUTS BY YEAR: MINIMUM PROGRAM

	PROJECT OUTPUTS BY YEAR					
	1	2	3	4	5	TOTAL
No. Students Trained						
First Aides-Alliance	500	900	900	1000	1000	4300
First Aides-PVOs	320	320	320	320	320	1600
Nurses/Medics-Alliance	70	140	140	210	280	980
Nurses/Medics-PVOs	80	80	80	80	80	400
Doctors-Alliance	-	10	10	-	-	20
Doctors-PVOs	10	10	10	-	-	30
Commanders-Alliance	5	10	10	-	-	25
Managerial/Supervisory-Alliance	20	40	40	40	20	160
Additional Health Providers/Facilities in Afghanistan						
First Aides	656	1140	1220	1300	1300	5616
Mobile Emer. Nurses	100	134	134	134	134	636
Mobile Health Clinics	15	30	30	30	30	151
Mobile Surgical Hosp.	4	7	7	7	6	31
Combat Surgical Hosp.	1	3	3	1	0	8
Evacuation Stations	16	16	16	16	16	80
Additional Managers/Supervisory Personnel						
All Types	34	57	60	60	60	271
Vaccination Programs						
Pilot	-	1	-	-	-	1
Regular	-	-	1	-	-	1
Public Education Programs						
Feasibility Study	1	-	-	-	-	1
Programs	-	1	1	1	1	4
Medical/Nursing Education						
Medical students	-	-	-	18	19	37
Nursing students	-	-	-	38	37	75
Additional Beds for Afghans in Pakistan						
Women	-	-	-	75	-	75
Children under age 15	-	-	-	75	-	75

* For inside Afghanistan, expected losses have already been subtracted.

TABLE OF PROJECT OUTPUTS BY YEAR: MODERATE PROGRAM

	PROJECT OUTPUTS BY YEAR					
	1	2	3	4	5	TOTAL
No. Students Trained						
First Aides-Alliance	700	1400	1400	1400	1400	6300
First Aides-PVOs	920	920	920	920	920	4600
Nurses/Medics-Alliance	140	210	210	210	210	980
Nurses/Medics-PVOs	210	210	210	210	210	1050
Doctors-Alliance	10	20	15	-	-	45
Doctors-PVOs	10	20	15	-	-	45
Commanders-Alliance	5	20	25	-	-	50
Managerial/Supervisory-Alliance	40	80	80	60	40	300
Additional Health Providers/Facilities in Afghanistan						
First Aides	1296	2180	2320	2320	2320	10436
Mobile Emer. Nurses	116	231	231	231	231	1040
Mobile Health Clinics	20	40	40	50	50	200
Mobile Surgical Hosp.	4	10	10	10	6	40
Combat Surgical Hosp.	1	3	3	3	1	11
Evacuation Stations	24	24	24	24	24	120
Additional Managers/Supervisory Personnel						
All Types	45	76	79	80	81	361
Vaccination Programs						
Pilot	-	1	-	-	-	1
Regular	-	-	1	1	1	3
Public Education Programs						
Feasibility Study	1	-	-	-	-	1
Programs		1	1	1	1	4
Medical/Nursing Education						
Medical students	-	-	-	25	25	50
Nursing students	-	-	-	50	50	100
Additional Beds for Afghans in Pakistan						
Women	-	-	-	100	-	100
Children under age 15	-	-	-	100	-	100

* For inside Afghanistan, expected losses have already been subtracted.

TABLE OF PROJECT OUTPUTS BY YEAR: MAXIMUM PROGRAM

	PROJECT OUTPUTS BY YEAR					
	1	2	3	4	5	TOTAL
No. Students Trained						
First Aides-Alliance	900	1800	1800	1800	1800	8100
First Aides-PVOs	1100	1100	1100	1100	1100	5500
Nurses/Medics-Alliance	140	210	280	280	280	1190
Nurses/Medics-PVOs	262	262	262	262	262	1310
Doctors-Alliance	12	25	18	-	-	55
Doctors-PVOs	12	25	18	-	-	55
Commanders-Alliance	6	25	30	-	-	61
Managerial/Supervisory-Alliance	40	80	80	60	40	300
Additional Health Providers/Facilities in Afghanistan						
First Aides	1620	2625	2625	2625	2625	12120
Mobile Emer. Nurses	145	289	289	289	288	1300
Mobile Health Clinics	25	50	50	62	62	249
Mobile Surgical Hosp.	6	13	13	13	7	52
Combat Surgical Hosp.	1	4	4	4	1	14
Evacuation Stations	30	30	30	30	30	150
Additional Managers/Supervisory Personnel						
All Types	45	76	79	80	81	361
Vaccination Programs						
Pilot	-	1	-	-	-	1
Regular	-	-	1	1	1	3
Public Education Programs						
Feasibility Study	1	-	-	-	-	1
Programs		1	1	1	1	4
Medical/Nursing Education						
Medical students	-	-	-	30	30	60
Nursing students	-	-	-	60	60	120
Additional Beds for Afghans in Pakistan						
Women	-	-	-	125	-	125
Children under age 15	-	-	-	125	-	125

* For inside Afghanistan, expected losses have already been subtracted.

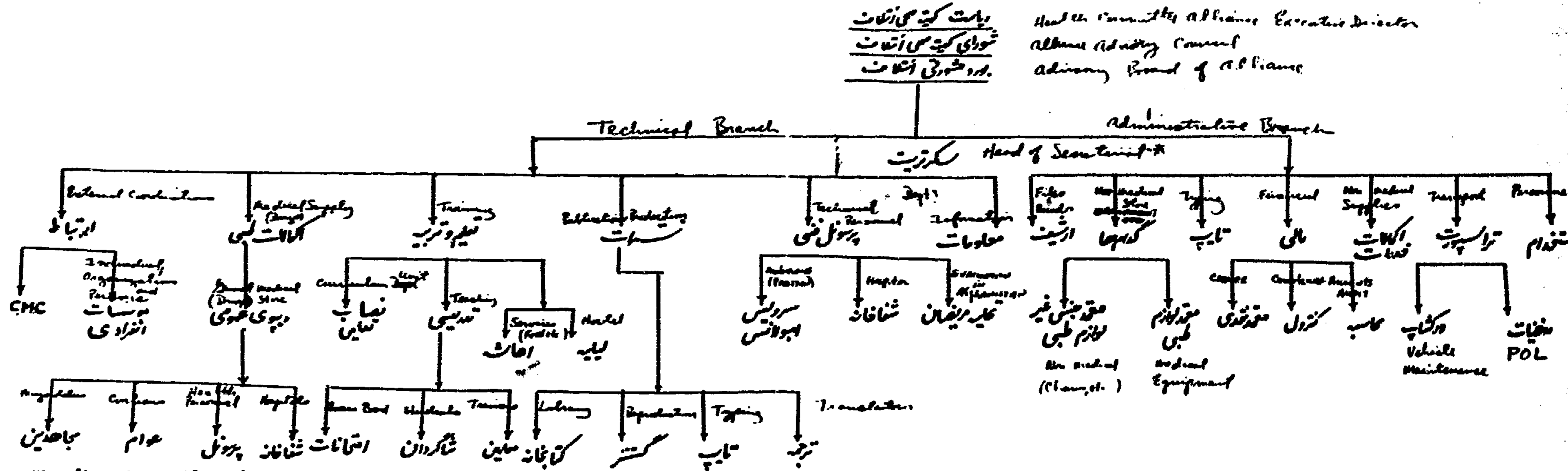
IV. NON-FINANCIAL ADMINISTRATIVE AND INSTITUTIONAL ARRANGEMENTS

A. ROLES AND COORDINATION AMONG IMPLEMENTATING INSTITUTIONS

At the end of the health planning team visit, the Health Committees of the Seven Party Alliance had made considerable progress and seemed willing to work together. They obviously need funds to do this and they also need technical assistance in getting them started on their way to developing a capability to plan, operate, monitor, and evaluate the larger, more complex health system envisioned by this project. During the discussions, they had made a number of points clear--they wished to be responsible for the Free Afghanistan health system including the administration of health facilities, programs, and evacuation systems inside Afghanistan; salary payments and family support allowances; education and training programs; supply systems; and monitoring and evaluation systems. The organogram of the Alliance Health Committee Secretariat, shown schematically on the following page and developed independently by them, shows their interests and their initial steps in organizational development.

As noted earlier, the PVOs had been meeting together and created an informal organization called the CMC. They had been discussing a number of issues including coordination between the PVOs and the Alliance Health Committee. This remained a major topic of discussion during the health team's visit. As noted earlier, the PVO position initially had been one of minimal contact and maximal independence while the Alliance view was that they should control everything. Discussions with the Alliance led to a modification of their views to allow PVOs to operate training and service activities with the approval of the Alliance. Discussions with many of PVOs receiving some US funds was encouraging but they felt (and the health planning team agreed), that policies and procedures would need to be worked out in some detail as to how approvals would be defined and obtained. This might best be done once the Alliance Health Committee Secretariat is funded. Obviously, the PVOs are reluctant to give up their independence until it is clear that the Secretariat is organized and working satisfactorily. However, the PVOs had also initiated coordination meetings between CMC and the Alliance. The Alliance indicated its further interest in coordination as demonstrated this by the presence of an Advisory Board and a liaison office in their organogram for the Secretariat.

It is also important to note that each PVO has its own policies, its own Board of Directors, and is funded by a number of sources. It should not be expected that all PVOs will agree to many of the changes now being discussed. It is also likely that the Alliance Health Committee will not wish to work with all of the current PVOs carrying out cross-border health programs and, as such, would not approve them. Careful liaison by AID and the technical assistance team will likely be required to maintain the good relationships between the Alliance and the PVOs.



* will add monitoring ("inspection") department - from Head of Secretariat

The need for technical assistance has been recognized from the beginning and endorsed by the ANPAC. The recommended technical assistance team composition is the same as in the original document, assuming an Alliance Health Program of moderate or maximum size. In Pakistan, this means a team leader, an operations officer, a training coordinator, and a supply specialist plus various local hire staff. It is envisioned to field a team that has experience in Afghanistan with at least one person experienced in Afghanistan during the war years. It is planned that a majority of the team will be non-Americans--a mixed American, British, French, and Pakistani team being most likely. If the technical assistance team also carries out the role of intermediary (explained in Subsection B following), then one additional expatriate position will be required--a Finance Officer.

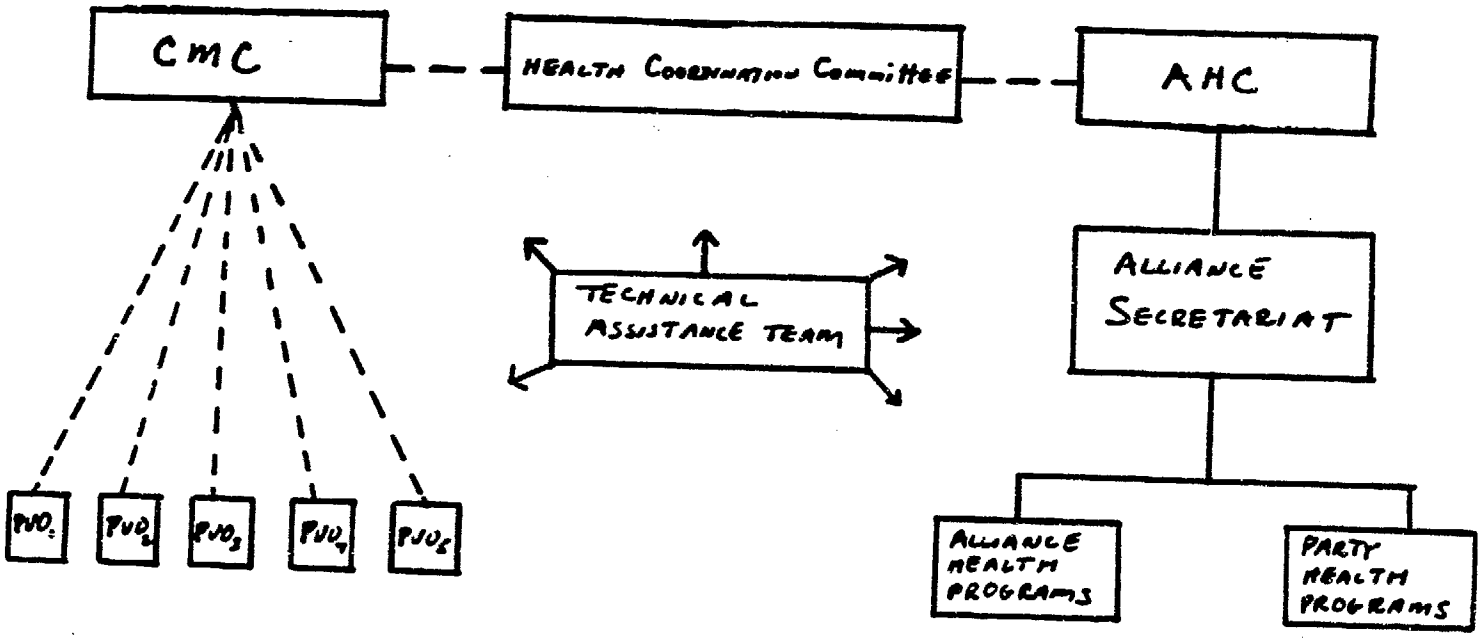
The technical assistance team will operate closely with the Alliance in assisting its organizational development, its training efforts, in helping it coordinate supply and logistics issues, and in relating to the PVOs and to AID and other outside agencies. This help will begin with the development of the first annual work plan and budget, a workshop on training, and other initial efforts requiring further discussion once funding is available (and the amounts are known!). Considerable work will be required in setting up the Secretariat and in developing its internal systems such as personnel, finance, supply, training, and so forth. It is expected that the Alliance and the technical assistance team will share office space although these details remain to be worked out.

In addition to the Alliance, the technical assistance team will work with PVOs. One clear fact that has emerged from discussions during the health team's visit is a desire on the part of the PVOs to have access to technical assistance as they expand their efforts. They have identified needs in curriculum development, pedagogy, and examination procedures, plus public community health planning at the present time. Based on the expectation of many specific needs, considerable short-term .technical assistance is built into the technical assistance effort.

During the health planning team's visit, the Government of Pakistan was devoting full efforts to the Geneva VII proximity talks and was unable to give the team any of its own views. As such, this task remains for AID and the Embassy. The GOP did assign a liaison officer to help with scheduling. Not only was the liaison officer an excellent organizer and translator, but his presence clearly demonstrated the importance of close GOP and USG coordination and shared perceptions on how to proceed. The health team hopes that the GOP will strongly endorse the AID activities in the health sector--better yet would be a joint effort.

SCHEMATIC DRAWING OF THE NON-FINANCIAL ADMINISTRATIVE ARRANGEMENTS IS SHOWN BELOW.

NON-FINANCIAL ADMINISTRATIVE ARRANGEMENTS



B. COORDINATION BETWEEN THE HEALTH PROJECT SUPPLY SERVICE AND THE COMMODITY EXPORT PROGRAM

The MSH Reference Report included a project supply service operating from Peshawar and staffed by a supply specialist and local staff. The supply service would operate in close coordination with the Swedish Committee for Afghanistan, also located in Peshawar, who have done an excellent job of providing locally procured medical supplies to the mujahiddin. The project supply service would focus on imports from the US or other countries and would grant funds, as required, to the Swedish Committee, for procurement of medicines in support of the Alliance Health Program and PVO programs. The supply service also included a US-based supply specialist to procure medical equipment in the USA and to coordinate with the DOD on McCollum transportation flights.

This report recommends that these arrangements not be changed. Effective control over drugs and medical supplies in Pakistan is crucial not only for prevention of losses but, as importantly, as a tool to encourage movement toward project goals and objectives. It is very important for there to be consistency in drugs, medical equipment, and medical supplies with the Alliance, between the Alliance and the PVOs, and between European and American PVOs. This requires a health project supply service that begins in the US for procurement of medical items and then continues in Pakistan where, in close collaboration with the Swedish Committee, it should provide all equipment sets, expendable supplies, and drugs for <u>both</u> the Alliance Health Program and the PVOs.

How then should the health project supply service relate to the proposed Commodity Export Program (CEP) now under design? It is highly recommended that the CEP contractor coordinate movement of all commodities in the USA and arrange their shipment to Pakistan either through McCollum flights or other mechanisms. In Pakistan, the health project supply service should be separate from the CEP but should investigate the potential for sharing of warehouse space with the CEP.

C. THE IMPLEMENTATION SCHEDULE

The implementation schedule for the first three years was described in the MSH Reference Report. Output levels were based on the budget estimates made at that time. At this point in time, the schedule of events is estimated to be about the same for the first three years.

The project outputs are based on the levels of funding which is unclear at this time and will undoubtedly affect the implementation schedule. Once the project is funded, AID will request the Alliance, with the help of the technical assistance team, to prepare a first year workplan which will serve as the implementation plan to begin activities.

V. FINANCIAL ADMINISTRATION OF AID FUNDS

A. FIVE OPTIONS FOR FINANCIAL ADMINISTRATION OF AID FUNDS AND THEIR ADVANTAGES AND DISADVANTAGES

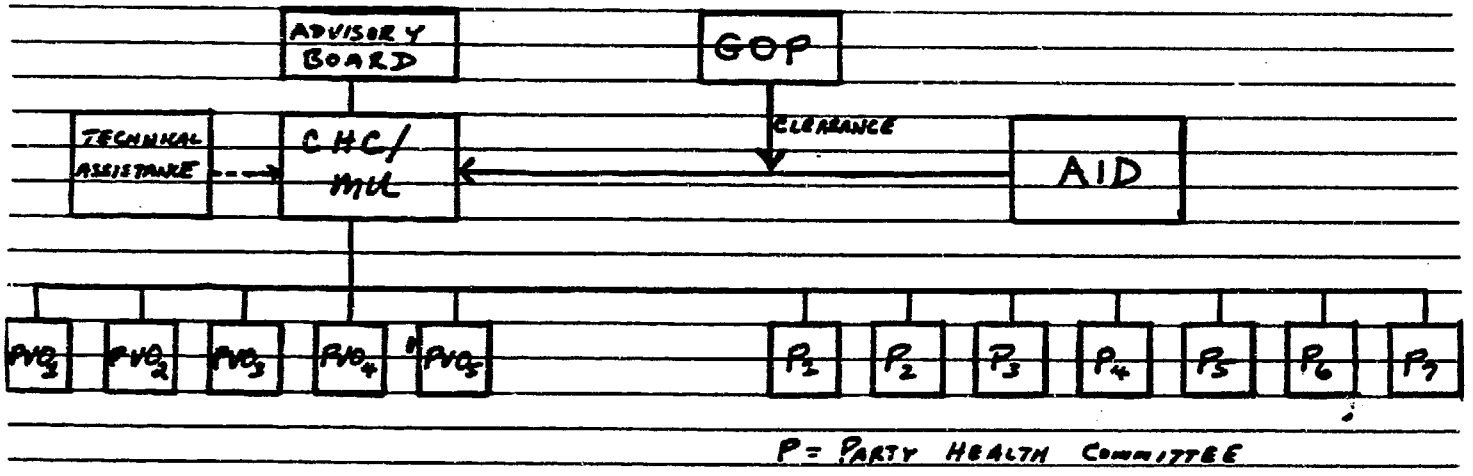
The five major options identified for the financial administration of AID funds in the first year of health activities are listed below. Each will be described and analyzed in the following sections.

SUMMARY OF FIVE MAJOR OPTIONS

1. Direct funding of a Coordinated Health Committee Management Unit
2. Direct funding of each PVO and direct funding of an Alliance Health Committee Management Unit
3. Direct funding of a PVO Health Committee Management Unit and direct funding of an Alliance Health Committee Management Unit
4. Direct funding of each PVO and indirect funding of an Alliance Health Committee Management Unit through an intermediary
5. Direct funding of each PVO and indirect funding of both the Alliance Health Committee Management Unit and each Party Health Committee through an intermediary

OPTION 1: DIRECT FUNDING OF A COORDINATED HEALTH COMMITTEE MANAGEMENT UNIT

Schematic Representation of Option 1

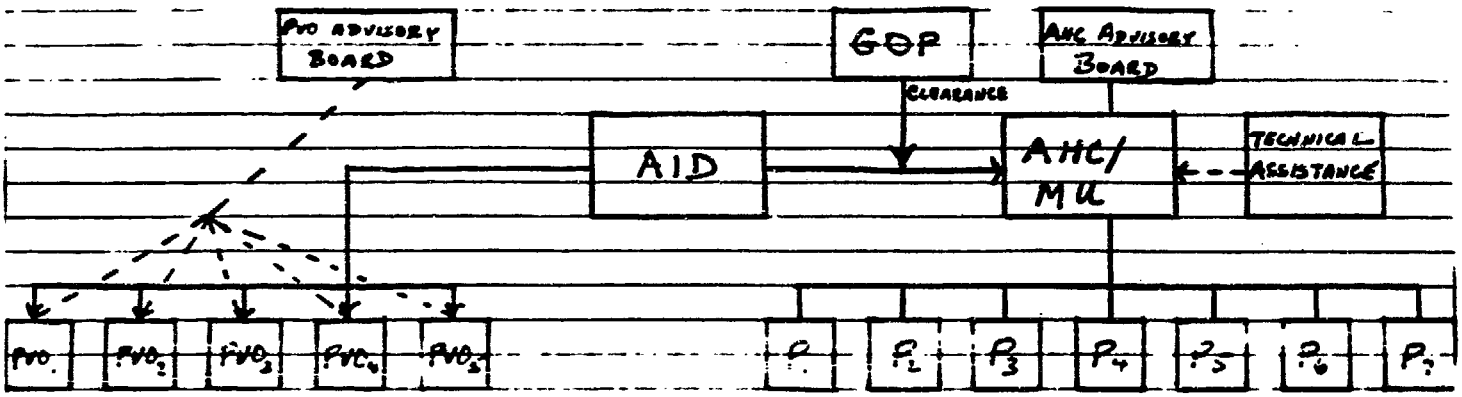


The main features of this option are that AID would directly fund a Coordinated Health Committee Management Unit (CHC/MU). The CHC/MU would have both party-appointed employees and PVO-appointed employees who work full-time on the CBA health programs. The CHC/MU would have various departments such as training, supply management, health operations, administration, and budget and finance. The CHC/MU would be directed by an Advisory Board which would have both party and PVO representation (AID and the GOP might insist on non-voting observer status). The CHC/MU would disburse funds and commodities to individual PVO's and individual parties and it would be responsible for financial management. Procedures would be worked out for clearance by the Government of Pakistan (GOP) before funds would be granted by AID to the CHC/MU. AID would monitor and audit the overall grant to the CHC/MU and its disbursements to PVOs and parties. Technical assistance would be provided to the CHC/MU but technical advisors would have no authority over granting or monitoring of funds.

The main advantages of this option are that it should promote progressive control of health services by Afghans and should enhance Alliance and PVO interaction. This option should be satisfactory to the Alliance members if they are in the majority. Its disadvantages include an uncertain legal status of this organization to receive direct AID grants (which may be overridden by using the "notwithstanding" clauses of AID's mandate) and the uncertain legal status of this organization in Pakistan; weak current programmatic and financial capability within the party health committee staff and in some PVO staff likely leading to a slow pace of implementation and problems with the quality of training, especially on the Afghan side; and maximum responsiblity on the CHC/MU for the supply of medical equipment/drugs with a subsequent serious concern would be whether these commodities would be regularly and properly supplied inside Afghanistan. This option has a stronger potential for diversion of funds and commodities into Pakistan. The development of monitoring systems would be difficult under this option further contributing to concerns about appropriate use of funds and commodities inside Afghanistan. The PVO's would find many disadvantages with this approach including loss of autonomy, cumbersome decision-making, probable foreign staff reductions, and may have concerns about the loss of organizational integrity. From the AID perspective, disbursement would probably be slow and AID would have more limited control as key decisions would be with the Advisory Board and the CHC/MU would directly distribute funds to individual PVO's and Party Health Committees. The CHC/MU meetings might be difficult in many ways including problems over US and other PVO salaries; use of foreign advisors and consultants, differences of opinion on location and control of health facilities and personnel inside Afghanistan, and so forth. The administrative burdens on AID would be high in monitoring of programmatic, commodity, and financial aspects, and accountability problems might dominate the AID-CHC/MU relationship.

OPTION 2: DIRECT FUNDING OF EACH PVO AND DIRECT FUNDING OF AN ALLIANCE HEALTH COMMITTEE MANAGEMENT UNIT

Schematic Representation of Option 2

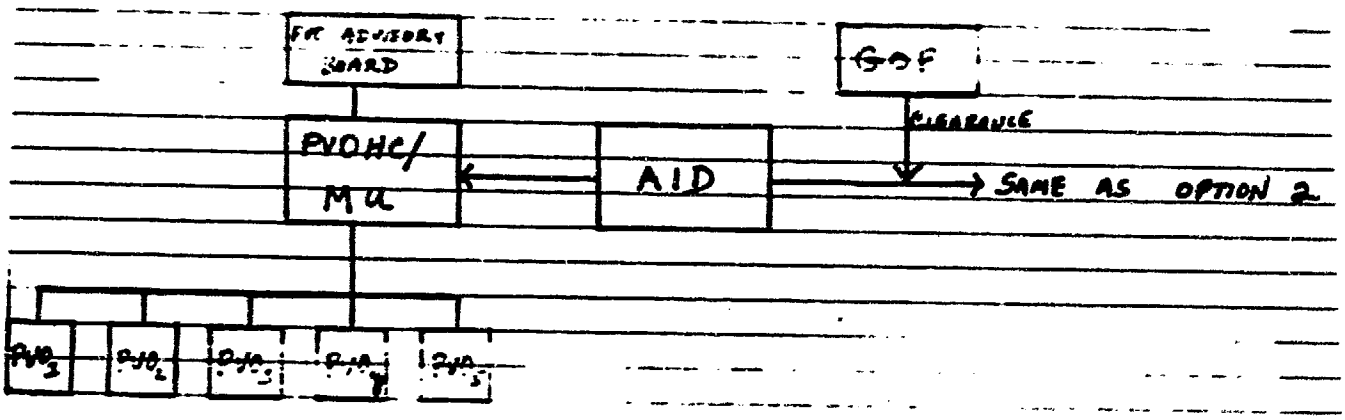


The main features of this option are that AID would directly fund each PVO separately and would directly fund an Alliance Health Management Unit (AHC/MU). The AHC/MU will have an advisory board to make policy decisions, to coordinate activities among themselves, to coordinate with PVOs, and, as required, to meet with AID. The PVOs may wish to have a similar advisory board. However, the flow of funds would be directly to each PVO and directly to the AHC/MU. The Government of Pakistan would clear the granting of funds according to procedures to be worked out between AID and the GOP. The costs of the AHC/MU would be paid for by AID and the AHC/MU would be staffed by Afghans appointed by the AHC Advisory Board. The AHC/MU would have various departments such as training, supply, health operations, administration, and budget and finance. In this option, the AHC/MU would directly disburse commodities and funds to the individual parties for training and health operations inside Afghanistan. Perhaps later on, the AHC/MU may operate Alliance Health Programs inside the country as well. AID would monitor and audit the individual PVO grants and the disbursements of funds and commodities made by the AHC/MU to the parties. Technical assistance would be formally provided to the AHC/MU and would be made informally available to the PVOs. However, the TA team would have no accountability for disbursing or monitoring of funds.

The advantages of this option are that it should be quite satisfactory to the PVOs and to the Alliance; should enhance the capability of the health committees to plan and implement their programs; and, with AID assistance, should lead to progressive control of the health services by Afghans. The disadvantages of this approach include the uncertain legal status of direct AID grants to the AHC/MU; the weak programmatic and management capability of the health committees at this point in time which could result in a slower pace of expansion of services inside the country; irregular availability of drugs, supplies, and equipment inside Afghanistan; weaker monitoring of health operations; and variable quality of training. The causes of these disadvantages center around the difficulty Afghans will have in disbursing funds and commodities based on adequate performance in use of the funds. For political harmony and cultural reasons, they will more likely disburse on some proportionality-based formula. In addition, the potential for diversion of funds and commodities into party health programs in Pakistan might be increased if the AHC/MU is in an actual disbursement role. This option might lead to rapid disbursement of funds to PVOs and slow disbursement by the Alliance. AID would have good control over PVO funds and more limited control over funds and commodities received by each party through the Alliance. This option places a high administrative burden on AID, especially regarding accountability of funds and commodities and these problems might dominate the AID-Alliance relationship in health.

OPTION 3: DIRECT FUNDING OF A PVO HEALTH COMMITTEE MANAGEMENT UNIT AND DIRECT FUNDING OF AN ALLIANCE HEALTH COMMITTEE MANAGEMENT UNIT

Schematic Representation of Option 3

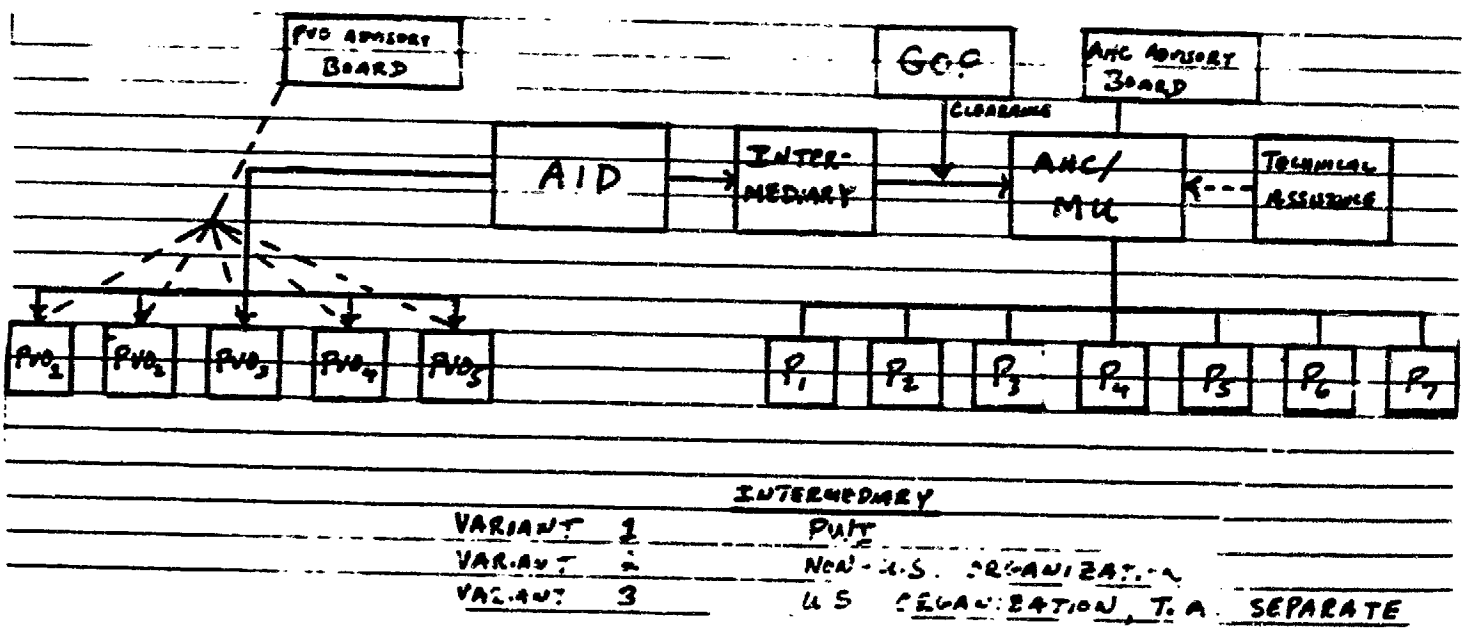


The main features of this option are that AID would not fund PVOs directly but would instead fund a PVO Health Committee/Management Unit (PVOHC/MU) which would fund the PVOs directly. The PVOHC/MU would have a PVO Advisory Board to make policy and to oversee operations. The PVOHC/MU would have various departments whose staff would be comprised of various PVO members and would be funded by AID. On the Afghan side, the arrangements are the same as in Option 2. AID would monitor and audit grants to the PVOHC/MU and the AHC/MU and would encourage coordination between the committees to maximize the pace of expanded services inside Afghanistan. Technical assistance would be provided to the Alliance and would be made available, on request, to the PVOHC/MU and its members.

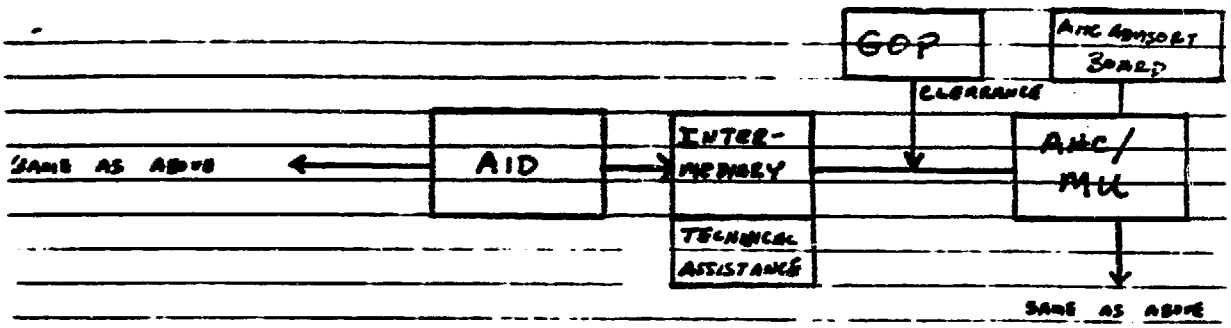
The advantages of this approach mainly lie in a formalized coordination among the PVOs. This might result in a more rapid pace of expanded services; better coordinated training, supply, and monitoring systems; and rapid disbursement of funds. Such an approach might make it easier for non-American PVOs to accept AID funds. The disadvantages include registration of a new entity in Pakistan; a weakened role of the AHC/MU vis-a-vis a strengthened PVOHC/MU; weakened AID control; Alliance dissatisfaction; and probable dissatisfaction by the parent headquarters of the individual PVOs.

OPTION 4: DIRECT FUNDING OF EACH PVO AND INDIRECT FUNDING OF AN ALLIANCE HEALTH COMMITTEE MANAGEMENT UNIT THROUGH AN INTERMEDIARY

Schematic Representation of Option 4, Variants 1-3



Schematic Representation of Option 4, Variant 4



The main features of this option are that AID would directly fund each PVO directly as in Option 2, but would provide AID funds and commodities to an intermediary who would disburse to the Alliance Health Committee/Management Unit based on mutually agreed plans and disbursement criteria. As before, the AHC/MU would have various departments and an Advisory Board and it would make disbursements to various parties for approved health activities. It may also operate its own health programs over time. The GOP would clear disbursements from the intermediary to the AHC/MU based on established policies and procedures. AID would monitor the intermediary and, on a selected basis, the AHC/MU and the parties. However, the intermediary would have a major role in financial and programmatic monitoring with an expectation of auditable record systems for activities in Pakistan. This option has four variants for the intermediary: (1) Pakistan Welfare International, (2) a non-U.S. organization as intermediary (e.g. a European or Muslim organization), (3) a U.S. organization but different from the technical assistance team, and (4) a U.S. organization that also provides the technical assistance. In Variant 4, the TA team has both an intermediary and a technical role.

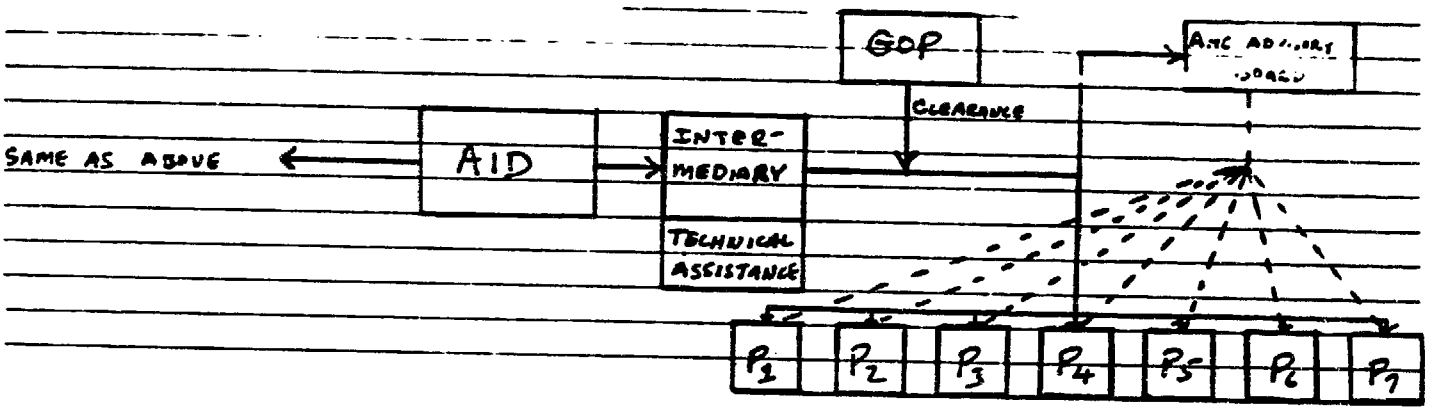
The main advantages of this option are that it the legal problems may be less, particularly if an American intermediary is used; the enhanced control by the intermediary should lead to stronger programmatic and financial management of AID funds and yet, if carried out in a coordinated fashion with the AHC/MU, should lead to enhanced capability of the AHC/MU and progressive control of health services by Afghans over time; and funds and commodities should have a greater likelihood of reaching the planned locations in Afghanistan. In addition, this option, particularly Variant 4, should lead to a rapid pace of expansion of services inside Afghanistan, better quality of training, more regular supplies of medical equipment and drugs, and an adequate monitoring system through close

supervision and control of funds in the first year or so and progressively increasing responsibility to the AHC/MU based on performance. For AID, this option should lead to more rapid disbursement of funds, adequate AID control through the intermediary, a more limited administrative burden, and better accountability of funds and commodities. This option should be satisfactory to the PVOs.

The disadvantages of this approach mainly lie with probable Alliance dissatisfaction, the uncertain position of the GOP on this issue, and increased costs and presence of an intermediary to help manage AID funds.

OPTION 5: DIRECT FUNDING OF EACH PVO AND INDIRECT FUNDING OF BOTH THE ALLIANCE HEALTH COMMITTEE MANAGEMENT UNIT AND EACH PARTY HEALTH COMMITTEE THROUGH AN INTERMEDIARY

Schematic Representation of Option 5



The main features of this option vis-a-vis Option 4 are that the intermediary disburses funds to the AHC/MU for its operations but also disburses funds and commodities directly to each party health committee for its operations based on plans made and approved by the AHC/MU. This option thus provides tighter financial control than Option 4 but otherwise is the same as Option 4 and also has four variants.

The main additional advantage of this option is the tighter control of funds by the intermediary which disburses funds and commodities directly to the Party Health Committees. This may prevent diversion of funds within the AHC/MU, maximize use of funds and commodities within Afghanistan, and increase accountability. The disadvantages are the same as for Option 4--Alliance dissatisfaction, the uncertain position of the GOP, and the higher cost and presence of the intermediary.

B. THE RECOMMENDED OPTION FOR FINANCIAL ADMINISTRATION OF AID FUNDS IN THE FIRST 1-2 YEARS

The table of the following page lists selected criteria for evaluating the five options described above and gives an unweighted score for the options.

Using these unweighted criteria, options 4 and 5 are preferable and these two are recommended--starting with Option 5 while the Alliance Secretariat is forming and moving to Option 4 as soon as possible. However, these scores do not reflect political criteria of either the USG or the GOP.

C. DISBURSEMENT PROCEDURES

The plan is to enter into a Cooperative Agreement or contract with a suitable organization to both act as the intermediary and to provide the technical assistance. The intermediary will keep a separate account of its internal operating expenditures and another account for use by the Alliance. AID would develop a disbursement plan to the intermediary, perhaps on an annual basis against a projected work plan and budget. That plan, once approved by AID, would be cleared with the Government of Pakistan. The intermediary would have developed the annual plan and budget along with the Alliance. The intermediary would disburse funds to the Alliance in small amounts initially, perhaps for one quarter and against specific tasks (Task Order System). As the Alliance demonstrated its capability to use and monitor funds well, the length and amounts of disbursements would be increased. The intermediary will maintain strict accountability of funds in Pakistan and will work with AID to develop accountability standards for inside Afghanistan.

TABLE

SELECTED CRITERIA FOR EVALUATING OPTIONS FOR FINANCIAL ADMINISTRATION OF AID FUNDS*

CRITERION	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
Organizational					
Legal Status of Imple. Organ.	+	+++	++	++++	++++
Mgt Capability-Programmatic	+	+++	++	++++	+++++
Mgt Capability-Financial	+	+++	++	++++	+++++
Promotes enhanced capability of Health Com.'s	+++	++++	++	+++++	+++++
Promotes progressive control of health services by Afghans	+++++	+++	++	++++	+++++
Max Use of Funds/ Commod. wi Afgh.	+	+++	+++	++++	+++++
Technical					
Rapid Pace of Expanded Services inside Afghan.	+	+++	+++	++++	+++++
Adequate Quality of Training	+	++	+++	++++	++++
Regular Supply of Med Equip/Drug inside Afghan.	+	++	+++	++++	+++++
Adequate monitoring system	+	++	+++	++++	++++
AID-Related					
Rapid Disbursement of Funds	+	+++	+++	+++++	+++++
AID Role and Control	+	+++	++	+++++	+++++
AID Admin. Burden	+	+++	++	+++++	+++++
Accountability of Funds/Commodities	+	+++	+++	++++	+++++
PVO Satisfaction	+	+++++	+++	+++++	+++++
Alliance Satisfaction	+++	+++++	++	++	+
UNWEIGHTED SUM OF +'S	24	50	40	67	73

Key: +++++ = strong advantage
++++ = advantage
+++ = neutral/no effect/or offsetting
++ = disadvantage
+ = strong disadvantage

* excludes political criteria of both US and GOP

VI. MONITORING AND EVALUATION

In view of the constraints imposed by the lack of an on-going health system in Free Afghanistan and the hostile environment, the monitoring system for health activities inside Afghanistan will be initially limited to collecting and analyzing quantitative information about the output targets and selected milestones that will demonstrate progress in moving toward the targets. Progress toward reaching the targets is subject to the vagaries of war such as supply losses, population movements, and physical losses from battles or bombing. As such, the targets will require regular adjustment based on prevailing conditions and monitoring itself must be based on "reasonable" progress. In addition, the needs for monitoring of services, programs, and numbers or clinics, etc., must be balanced by the need for security in preventing Soviet and DRA forces from gaining information that might cause them to interdict these health activities.

However, output information is needed and, in addition, some subjective measures of the quality of work by the paramedical and first aides will be necessary. Data collection will be done through both formal and informal approaches. The Alliance Secretariat will be one formal mechanism and will have a department of Monitoring and Evaluation. In addition, the Swedish Committee already has a relatively good system for monitoring supply movements and usage by province. This data is helpful in understanding how busy facilities are based on their consumption of supplies. The technical assistance team will help organize and systematize these mechanisms and, in addition, will supplement these approaches with informal interviews with travellers from Afghanistan, both Afghan and foreign. Health activities occurring in Pakistan will be closely monitored.

Routine technical and administrative monitoring will be done by the AID offices in Peshawar and Islamabad in conjunction with the intermediary. AID will require semi-annual and annual reports from the intermediary, the Alliance, and PVOs receiving grants in the health sector. In addition, AID will schedule an outside interim evaluation in the second year of activities. From these approaches AID will develop the criteria to determine whether or not the project should be expanded and when.